Paying for Value

Good healthcare doesn't have to be so expensive.

This paper will discuss how changing our healthcare payment system to pay for value will promote better outcomes and reduce costs. Value is defined as quality divided by cost, so increasing quality and/or lowering cost produces more value.

The new healthcare law, called the Patient Protection and Affordable Care Act (ACA), will increase coverage of Americans. But ACA has come under much criticism because of the concern that it will not reduce the unsustainable increases in cost of healthcare. There are many suggestions to reduce the increasing costs of health care, such as administrative simplification (reducing paperwork), promoting the right preventive care, having patients make better cost-conscious choices (by paying a larger share of the cost), and reducing defensive medicine.

The biggest remedy though I believe to reduce healthcare costs is to pay for value. Our current payment system is based on paying more for more expensive care, and is not based on paying for the most effective care. Our current system pays more for volume (more tests, treatments), and actually pays less to more efficient hospitals and physicians who utilize less. The payment system has been based on the premise that more care is better. But with research we have learned that sometimes more tests and more treatment simply result in more expenses, and do not necessarily result in better outcomes.

Dartmouth research has shown large variations in Medicare spending by hospitals and physicians in different regions. There are many regions that spend over twice as much as others, and the care in high spending regions is not higher in quality but often lower in quality. Higher quality has been found to correlate with more efficient care.

For example, in Miami (where quality is actually quite low), the average Medicare payment per year is over $16,000 per patient while many regions in Iowa and the upper Midwest (with some of the highest quality) are paid $6,000-7,000 per patient per year. This huge difference Dartmouth found is primarily due to more tests and treatment, more days in the hospital, and more visits to specialists. Dartmouth researchers have estimated that our country overall is wasting over 30% of our healthcare dollars on ineffective and unnecessary care.

If physicians and hospitals all over the country practiced like the upper Midwest, our country could save over 30% of our healthcare costs. Researchers pointed out that even in the Midwest we can improve quality and cost-effective care. I suspect that even the most liberal politicians and the tea party politicians agree that we cannot afford to waste over 30% of our health care dollars.

The higher spending regions have many excuses for this huge variation in Medicare spending, but obviously people in Miami are not twice as sick as Iowans. Dartmouth recently published a study where Medicare beneficiaries were followed after they moved to higher spending regions, and not only did the patients have more doctor and hospital care and spending go up to match the new region, the patients actually received more diagnoses (i.e. became "sicker"). On the other hand, the people who moved from the high spending regions to the lower spending

regions actually had lower Medicare expenditures to match the region, indicating that it is not the patients, but doctors and hospitals who determine how much to spend. And the patients who moved to high spending regions became “sicker”, because the doctors either said so or they caused more illness.

Being admitted to a hospital for ineffective or unnecessary tests or treatment that leads to a complication can be very expensive. More care is not better care. The payment system needs to be changed to reward efficient delivery of high quality, evidence-based, patient-centered (better) care, not more expensive care.

Medicare has had a small program called Value-based Purchasing for many years, and some insurance companies (such as Wellmark’s Collaboration on Quality) have paid for quality improvement. ACA also has stipulations for the Center for Medicare Services and the Institute of Medicine to develop more pay for value initiatives.

Fortunately, Iowa’s federal legislators have been leaders in promoting pay for value. But in the coming year I expect higher spending and lower quality regions will continue to block or slow down the process of reforming our payment system to pay for value.

We’ll get what we reward-- higher quality and more effective healthcare. It is time to pay for value, not volume. Good healthcare doesn’t have to be so expensive.

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